**TODD E. PACZEWSKI, D.M.D., LCC**

1500 WYOMING AVENUE, FORTY FORT, PA 18704

PHONE: 570-287-2500 FAX: 570-288-4345

**Written Financial Policy**

Thank you for choosing Dr. Todd Paczewski DMD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

**Payment options:**

Payment for services are due when services performed (unless financial arrangements have been made).

You can choose from: Cash, Check, Visa, MasterCard, American Express or Discover Card.

We offer a 5% courtesy adjustment to patients who pay in full with cash or check prior to beginning of a treatment for plans of $1000.00 or more.

-Convenient Monthly payment Plans \*\* from Care Credit & Honesdale National Bank

\*Allows you to pay overtime \*No annual fees or pre-payment penalties for plans over $1000.00

**Please Note:** Dr. Paczewski requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

We accept payments in thirds for treatment over $1000.00. For plans requiring multiple appointments, alternative payment arrangements may be permitted. For larger, more comprehensive treatment plans over $4000.00, a 10% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and direct-bill them for reimbursement for your treatment\*\*\*

Dr. Paczewski charges $35 for returned checks. **Statements past 60 days are subject to a handling fee of $4.95 or 5% whichever is greater for every billing statement. Payment is due at time of service for deductibles, co-pay and non-insurance patients. If payment is not received a fee of $4.95 will be applied per statement mailed.**

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

\*\*subject credit approval

\*\*\*However, If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.